STATE OF MASSACHUSETTS
WORKERS' COMPENSATION COLA DATA FORM

I. IDENTIFICATION OF WORKER (To Be Completed By Requesting Office)

Worker's Name | Worker's Social Security Number

Employer's Name | Date of Accident

Signature of Requesting Official | Return Form to (Requester's Address)

Title Date

II. WORKER'S AUTHORIZATION FOR RELEASE (To Be Completed By Worker)

To allow determination of the proper amount of workers' compensation payments, I hereby authorize release of the information requested below to the requesting official shown above. This authorization is valid for a period of 12 months from date shown below.

Worker's Signature | Date

III. SOCIAL SECURITY INFORMATION (To Be Completed By The Social Security Administration)

A. ☐ Partial offset involved. Any increase in workers' compensation payments will cause additional offset of Social Security disability payments.

B. ☐ Offset does not apply effective with the date shown below. Any increase in workers' compensation can be paid beginning with that date without affecting Social Security disability payments.

- Worker age 62/65 _____ (month/year)
- Disability terminated _____ (month/year)

C. ☐ We have no record of any Social Security benefits being paid to the worker under the above Social Security number. Please verify its accuracy and resubmit. Mark the new CR-28 "Second Request - SSN Corrected."

D. ☐ Worker is receiving Social Security payments other than disability or disability claim denied.

E. ☐ If A, B, C, or D do not apply, complete the following:

1. Total Family Benefits (as of first possible month of offset)
2. 80% Average Current Earnings (ACE)
3. Redetermined ACE (only if applicable)
4. Redetermined ACE Effective Date (month/year)
5. Total benefits payable as of date in item 4 but before redetermination

F. ☐ Supplemental Security Income _____

SSA Representative Signature Circle One Date

DO PSC ODO

Attention: Requesting Official (Retain this document in your files for future reference.)

FORM CR-28